Application for Authority to Employ Workers with Disabilities at Special Minimum Wages

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

NOTE: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1215-0005
Expires: 03-31-01

This is an application for the authority to employ workers with disabilities at special minimum wage rates under the Fair Labor Standards Act (FLSA), Walsh-Healey Public Contracts Act (PCA), or Service Contract Act (SCA). Please submit one copy of the completed form, and any attachments, to the address shown above. Retain a completed copy for your records. A certificate may not be granted unless a properly completed application has been received and approved. U.S.C. 201, et seq.

1. This is a request for authority to employ workers with disabilities for:

A. ☐ Work Center

☐ Hospital/Residential Care Facility (Patient Workers)

☐ Business Establishment (Special Worker)

B. Check One:

☐ Initial application (Complete all items)

☐ Renewal application (Please make any necessary corrections to reprinted information.)

C. ☐ Request for Temporary Authority by State Vocational Rehabilitation Agency or Veterans Administration

2. Name of Employer: _____
(Work Center, Hospital/Institution, Business, School Providing Placement)

Street Address: _____

Mailing Address (if different than street address): _____

City: _____ County: _____

State: _____ ZIP Code: _____

Telephone: _____

4. Parent Organization if different from that listed in (2).

Name: _____

Address: _____

Check here if mail is to be sent to parent organization rather than #2. ☐

FOR OFFICE USE ONLY

Certificate Number _____
Effective Date ___/___/___
Expiration Date ___/___/___
Print Certificate: **Yes** ☐ **No** ☐
RO _____ **DO** _____
REMARKS: _____ **EMPLOYEES** _____

3. List the name and address(es) of all branch establishments, (BR) supported employment sites (SE), or school work experience program sites (SWEP) to be covered by this certificate. If you are making an initial application (no previous authority), enter the number of workers expected to be employed in each program. If you are providing renewal information, list the number of workers in the specific program areas on the last day of the most recent representative quarter.

Attach additional sheets if necessary.

(BR, SE, or SWEP)	NAME & ADDRESS OF SITE	NUMBER OF WORKERS

5. Status: (check one)

☐ Public (State or local government) (PU)
☐ Private, For Profit (PP)
☐ Private, Not For Profit (PN)
☐ Other

6. Do you manufacture items for the Federal Government under
PCA? ☐ Yes ☐ No

Do you perform any services for the Federal Government under SCA? ☐ Yes ☐ No

7. Primary disability group employed (check one):

☐ Mental Retardation (MR)
☐ Mental Illness (MI)
☐ Visual impairment (VI)
☐ Hearing impairment (HI)
☐ Alcoholism (AL)
☐ Drug Addiction (DA)
☐ Neuromuscular (NM)
☐ General - No primary group (GI)
☐ Age Related (AR)
☐ Developmental Disability (DD) Specify:
☐ Other (OT) Specify:

Public Burden Statement

We estimate that it will take an average of 45 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Administrator, Wage and Hour Division, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form WH-226-MIS
Rev. Dec. 1996

8. Estimated number of workers with a disability employed during the fiscal year ending (Date) _____ under this certificate is _____. (The number of workers should include all locations covered by this certificate.)

WAGE PAYMENT DETERMINATION

9. PREVAILING WAGE DETERMINATION

Please provide the following information on the four largest current contracts whether the workers with disabilities are paid an hourly rate or a piece rate. The prevailing rate should reflect the rate paid to experienced nondisabled workers in the vicinity for work utilizing similar methods and equipment. if more than 3 sources were used, attach an additional sheet headed "Prevailing Wage Determination" and provide the information obtained from these sources. (Section 14(c)(2)(B) and Part 525.10.)

Description of Work (e.g. collating, hand assembly, janitorial)	Sources (Name of Firm and Person Contacted)	Date of Contact	Prevailing Wage Provided by Source	Prevailing Wage Determined by Applicant
	1.			
	2.			
	3.			
	1.			
	2.			
	3.			
	1.			
	2.			
	3.			
	1.			
	2.			
	3.			

10. HOURLY RATES

a. How many workers with disabilities employed under the terms of this certificate are paid an hourly rate? _____ (If the answer is 0, go on to question 11.) How frequently do you rate/evaluate each worker's productivity? _____

b. Attach to this application productivity rating/evaluation forms for three currently employed workers with disabilities who are paid hourly rates. Include all material relating to the evaluation which shows the disabled workers' individual productivity in proportion to the wage and productivity of experienced nondisabled workers performing essentially the same type, quality and quantity of work in the vicinity.

11. PIECE RATES

a. How many workers with disabilities employed under the terms of this certificate are paid piece rates? _____(If the answer is 0, go on to question 12.)

b. Please provide the following information about the four largest current contracts on which workers with disabilities are paid piece rates and attach supporting time studies or work measurements.

Description of Work (e.g. delabel cones)	Prevailing Wage Determined for this Job (Expressed in a Rate Per Hour)	Standard Productivity (Units/Hour)	Piece Rate Paid to Workers (Rate Per Unit)

12. TEMPORARY AUTHORITY	**(FOR USE BY VOCATIONAL REHABILITATION COUNSELORS AND VETERANS ADMINISTRATION TRAINING OFFICERS ONLY)**
a. ☐ Temporary Certificate issued by a rehabilitation agency	b. ☐ Extension of Temporary Certificate Check one ☐ Do not extend. ☐ Extend as described below. (May not be for more than 12 months.)
From __ __ __ To __ __ __	From __ __ __ To __ __ __

13. REPRESENTATIONS AND WRITTEN ASSURANCES

I certify that I have read this form and, to the best of my knowledge and belief, all answers and information given in the application and attachments are true; that the representations set forth in support of this application to obtain or continue the authorization to pay workers with disabilities at subminimum wage rates are true; and that the authorization, if issued or continued, is subject to revocation in accordance with the provisions of 29 CFR 525.

I represent that as set forth in the regulations governing the employment of workers with disabilities, the following conditions exist (or will exist for initial applicants):

(1) workers employed (or who will be employed) under the authority in 29 CFR 525 are disabled for the work to be performed;

(2) wage rates paid (or which will be paid) to workers with disabilities under the authority in 29 CFR 525 are commensurate with those paid nondisabled experienced workers in industry in the vicinity for essentially the same type, quality, and quantity of work;

(3) the operations are (or will be) in compliance with the FLSA, PCA, SCA, and Contract Work Hours and Safety Standards Act, an overtime statute for federal contract work;

(4) no deductions will be made from the commensurate wages earned by a patient worker to cover the cost of room, board or other services provided by the facility;

(5) records required under 29 CFR Part 525 with respect to documentation of disability, productivity, time studies or work measurements, and prevailing wage surveys will be maintained.

Further, I certify that:

(1) the wage rates of all hourly-rated employees paid in accordance with section 14(c) of FLSA will be reviewed at least every six months, and

(2) wages paid to all employees under FLSA section 14(c) will be adjusted at periodic intervals at least once a year to reflect changes in the prevailing wage paid to experienced nondisabled workers employed in the vicinity for essentially the same type of work.

14. SIGNATURE OF AUTHORIZED REPRESENTATIVE

Name (Print or Type) _____ Title _____

Signature _____ Date _____

INSTRUCTION SHEET

GENERAL INSTRUCTIONS

1. This application is to be used to apply for a subminimum wage certificate under the Fair Labor Standards Act (FLSA), the Walsh-Healey Public Contracts Act (PCA), and the Service Contract Act (SCA). Payment of subminimum wages to workers with disabilities is authorized only under certificates issued under section 14(c) of FLSA.

2. This report is authorized under section 14(c) of FLSA. While completion of this form is voluntary, authority to pay less than the applicable minimum wage will not be granted unless a properly completed application is submitted.

3. Complete one copy of this form and send to the Wage and Hour Division. Keep a photocopy for your records.

4. Do not submit an application for each branch establishment. List the names of branch establishments in the space provided in item 3. Enclaves, supported employment work sites, and school work experience sites should also be reported in item 3. **A form WH-226-A must be completed for each site where workers with disabilities are employed.**

SPECIAL INSTRUCTIONS FOR SCHOOL WORK EXPERIENCE PROGRAMS

The rehabilitation counselor or coordinating official of the school may submit a group application covering all of the students with disabilities and all of the employers participating in a school work experience program. Employers are responsible for compliance with all applicable child labor laws, minimum wage standards, certificate and recordkeeping requirements. The students participating in a school work experience program must be paid commensurate wage rates based upon the students' productivity in proportion to the wage and productivity of experienced nondisabled workers performing essentially the same type, quality, and quantity of work in the vicinity in which the students are employed. Complete all items except numbers 6 and 12.

Item 1(A) - Check "Business Establishment (Special Worker)"
Item 2 - Enter identifying information for the school
Item 4 - Enter School District information
Item 5 - Check "Other" and enter "SWEP."
Items 9 and 11 - Complete for the four types of work in which the greatest number of students with disabilities are employed. If fewer than four types of jobs exist, enter n/a in the "Description of Work" blocks which aren't used.
Item 14 - Must be signed by the counselor or coordinating official of the school

SPECIAL INSTRUCTIONS FOR VOCATIONAL REHABILITATION COUNSELORS OR VETERANS ADMINISTRATION TRAINING OFFICERS

Complete all items except #6.

Item 1(A) - Check "Business Establishment (Special Worker)"
Item 1(C) - Check
Item 2 - Enter name and location of employer where workers with disabilities are to be placed.
Item 4 - Enter the name and address of the Veterans Administration Office or State Vocational Rehabilitation agency which is seeking temporary authority or an extension
Item 5 - Check "Other" and enter the type of business in which the worker with a disability is being placed.
Items 9 and 11 - Complete for the worksites where the workers with disabilities will be employed.
Item 14 - Must be signed by the Vocational Rehabilitation Counselor or Veterans Administration Training Officer.

* U.S.GPO:1999 454-845/12707